August 9, 2002

TO: **James P. Mayer, Executive Director**
Toby Ewing, Project Manager
Little Hoover Commission

FROM: **Laurie A. Soman, Senior Policy Analyst**
Center for the Vulnerable Child
Children's Hospital Oakland

RE: **Status of California's Children in Foster Care**

Thank you for the opportunity to respond to your request for input regarding the pace and direction of reform of the foster care system in our state, three years after release of your report, "Now in Our Hands: Caring for California's Abused and Neglected Children". I was proud to serve on the advisory committee to the report and am pleased that you are following up on progress in the intervening years.

I believe that some strides have been made in improving care for these children; for example, the establishment of foster care public health nurses at the county level is one example of a strategy that seems to be making a big difference at the local level for both social services staff and children in foster care. At the same time, a number of your fundamental findings and recommendations have not been addressed by the state. In addition, there are several specific issues that have long been noted as problematic for these children and require further attention. I would like to address those specific issues, including the following:

Immediate Access to Medi-Cal Following Child Removal

Many counties experience delays in achieving Medi-Cal eligibility for children who have been removed from their homes to foster care. While some counties have reduced the time from detention hearing to eligibility to a few days, that is the exception in the state. In some counties the eligibility process may take several months. This time lag-- whether days or months-- remains a serious barrier to non-emergency health care for these children, when all professional standards of care call for timely primary care and health and mental health assessments, all of which are difficult to obtain without established health care coverage.

Despite years of discussion of this problem, we still do not have a successful mechanism for achieving immediate Medi-Cal eligibility for children as they enter the foster care system. We had hoped to see a system, perhaps something akin to the Family Pact approach, to guarantee children entering foster care immediate Medi-Cal eligibility following the detention hearing 72 hours after removal from the home. Such a system has not yet been implemented. It is possible that implementation of the proposed CHDP Gateway Program, scheduled for April of next year, may address this problem by providing Medi-Cal coverage for 60 days. If Gateway is

implemented, its impact on access to coverage for children in foster care should be evaluated; if Gateway is not implemented, we still need a mechanism for immediate Medi-Cal coverage.

Elimination of "Other Insurance" as an Access Barrier

As you know, a number of foster children enter the system with some form of private health coverage; in these cases, the health care provider must bill the other health coverage first and obtain a denial before Medi-Cal can be billed. In some cases, health coverage information is available, the other coverage responds quickly, and timely access is achieved. Unfortunately, more often, in providers' experience, coverage information is not available or is extremely difficult to obtain, the child may not be in a geographic location covered by the private insurance company, or the other coverage does not respond in a timely manner or does not respond at all.

Many of us have recommended to the Department of Health Services that it develop a mechanism to authorize providers to bill Medi-Cal first for those foster children with both Medi-Cal and another form of health coverage, with the Department assuming responsibility for billing the other health coverage to recover the costs of care. It was our understanding that the Department had agreed to this approach and was to issue an all-county letter establishing this as policy, but to date we have not seen this letter. This is a relatively simple issue to resolve that will increase access to care for the children and reduce the burden on those providers still willing to treat children in foster care.

Access to Mental Health Services

I see this as the single largest access problem for children in foster care in our state. Your report was very clear in calling for expanded mental health services, a plan for delivery, and evaluation of their delivery. Access to mental health services is abysmal for children in out-of-home placement in California. Lack of appropriate providers, particularly for children under age five and for psychiatric services including medication management, is certainly a factor; many sources have linked inadequate provider capacity to poor reimbursement rates. From a systems perspective, a significant problem is the implementation of county-based mental health managed care. This system contradicts the experiences of many foster children, who either are placed out of county of residence (where their Medi-Cal originates) or who require services that are available only in other counties. We continue to hear of numerous problems in access for children in either of these circumstances. The mental health administrative services organization, Value Options, that provides access to a network of out-of-county mental health providers, is useful, but its limitations prevent it from meeting the needs of many abused and neglected children. For example, it covers few services, primarily outpatient therapy, and not others that may be needed by these children, such as day treatment. In addition, it does not cover children in the AB 3632 program, who often are placed in group homes outside their counties of origin. Finally, I understand that not all counties are participating in Value Options.

Despite your call for evaluation of service delivery to these children, including delivery of mental health services, there appears to be little or no monitoring or oversight of county mental health managed care plans and access to mental health services by the State Department of

Mental Health. Some counties are contracting all or part of their mental health utilization management to private managed care organizations which then impose non-Medi-Cal standards--e.g., limiting outpatient therapy to two visits per month, rather than the number of visits the child requires under medical necessity standards, as mandated by federal EPSDT. State oversight should have identified and corrected this barrier to access. Legislation enacted last year (SB 745) called for monitoring by DMH of access to mental health services for children placed in group homes, yet the Department acknowledges not having begun this monitoring. I strongly urge you to continue to press for oversight and evaluation of mental health services to this population of children that is known to have extraordinarily high mental health needs.

Monitoring and Evaluation of Child Abuse/Foster Care Services

The Little Hoover Commission report cited the need for monitoring and evaluation of mental health, health, dental and vision care services for children who have been abused or neglected, yet we see little evidence that this oversight is occurring. As noted above in the discussion of mental health access, state failure to monitor and evaluate service availability and delivery often results in reduced access for vulnerable children. It also makes it impossible to determine if our public dollars are being well spent. I strongly support your report's recommendations to evaluate and assess our current services, their delivery to foster children and families, and their outcomes, and urge you to continue to reiterate them.

Thank you again for your attention to this needy and neglected population of children and families. Please feel free to contact me (510-428-3885 x 2712 or Lsoman@mail.cho.org) if you have questions or would like further information.

cc: Mary Dean
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